

Counseling Department Policy and Procedures Manual

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PHILOSOPHY

Every individual has the right to live independently, enjoy self-determination, make choices, contribute to society, pursue meaningful careers, and enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society. (See Rehabilitation Act Amendment of 1992, October 1, 1992, Title I.)

Consistent with the policies of the Americans with Disabilities Act, case management services implementation includes: respect for individual dignity; personal responsibility; self-determination; and pursuit of meaningful careers based on the informed choice of individuals with disabilities; respect for the privacy, rights, and equal access of individuals with disabilities; inclusion, integration, and full participation of individuals with disabilities; support for the involvement of the family, advocates, or authorized representatives if desired or requested by the individual with the disability; and support for the individual and systemic advocacy and community involvement.

The philosophy of the WWRC Case Management (CM) system is founded upon the basic premise that all citizens of the Commonwealth, regardless of their mental, cognitive or physical capacity, have the right to work and to lead useful and productive lives. WWRC provides the comprehensive rehabilitation services that persons with disabilities often need to achieve their goals. The manner in which these services are provided can make the difference between dependence and independence.

The Rehabilitation Counselor/Social Worker (RC/SW) in partnership with the customer and sponsor, is entrusted with the management of a variety of services in the form of human, facility and fiscal resources. The case management system must promote accountability for these resources. It is critical that these resources be used efficiently and be combined effectively in consultation with the sponsor, and in accordance with State and Federal regulations and DRS policy.

The CM System will provide the necessary guidance to the interdisciplinary team to ensure uniform CM practices. In order for this system to function effectively, the RC/SW must be a competent, responsible, and caring professional. The RC/SW, as the team leader, is the individual who is ultimately responsible in working with the customer to ensure achievement of his/her rehabilitation goals. This system must promote continuity from pre-admission through employment and independent living and community placement. The case management system also promotes RC/SW accountability and the positive life outcomes of individuals with disabilities who participate in WWRC services.

(Reviewed 10/03)

(Revised 6/00)

MISSION

In partnership with people with disabilities, WWRC provides and facilitates an integrated customer focused spectrum of services and develops/promotes innovations, access, education and services to empower customers to achieve greater economic self-sufficiency and optimum independence in community living. The Case Management System supports the Center's mission by providing a customer-driven environment which enables persons with disabilities to achieve their goals through a systematic and consistent interdisciplinary process, and by establishing and maintaining a process of needs assessment, individual plan development, implementation, monitoring, evaluation, and advocacy education, leading to achievement of the customer's goals. The Case Management System and Center missions in turn support the DRS mission of empowering individuals with disabilities to maximize their employment, independence and full inclusion into society.

(Reviewed 10/03)
(Revised 6/00)

CASE MANAGEMENT SYSTEM OBJECTIVES

- ⇒ To develop a strong partnership with individuals with disabilities to foster the development of personal responsibility in achievement of their rehabilitation goals.
- ⇒ To provide effective team leadership which promotes communication and continuity of day and evening services.
- ⇒ To seek and act on information for continuous quality and program improvement which promotes positive customer independent living and employment outcomes.
- ⇒ To control operational costs and customer stays.
- ⇒ To develop a strong relationship with sponsors.
- ⇒ To promote and model customer self-advocacy and personal responsibility.

INTERDISCIPLINARY TEAM

The case manager is the leader of an interdisciplinary team which consists of the customer, case manager, family, sponsor, and all necessary WWRC staff to assist the customer in achieving program goals. It is the responsibility of the case manager to provide team leadership and facilitate communication; and ensure that service goals are consistent with the customer's rehabilitation goal. The case manager is also responsible to ensure that team meetings are conducted in an efficient and effective manner which maximizes resources and coordination of services.

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(Revised 6/00)

REHABILITATION COUNSELOR/SOCIAL WORKER ROLE

The Rehabilitation Counselor/Social Worker (RC/SW) serves a vital role throughout the rehabilitation process. The responsibilities of the RC/SW clearly indicate that he/she must possess solid rehabilitation knowledge, in-depth payer knowledge and expertise, and a seasoned judgment to balance the diverse, often conflicting goals, of the customer, and sponsor. (and WWRC professional staff). The RC/SW must perform his/her duties in an impartial manner. The RC/SW must obtain the trust of, maintain credibility with, and be viewed by all parties involved in the rehabilitation process as an independent resources who is an integral member of the rehabilitation team.

In partnership with the customer, this individual is responsible for the total rehabilitation program. The RC/SW coordinates and leads the interdisciplinary team, and makes the decisions with the sponsor, customer and team regarding services to be provided and the sequencing of the services. The authority for the purchase of services at WWRC is through this person who coordinates with the sponsor. He/she generates the interdisciplinary service plan and negotiates same with the customer, sponsor and team. The RC/SW ensures that each discipline's goals and plans support the IPE. The RC/SW also provides career guidance and counseling, as well as basic supportive and adjustment counseling.

The RC/SW ensures communication and coordinated service provision between day and evening services.

The RC/SW is responsible and accountable for: the financing and management of each case; knowledge of insurance products and financing options. An essential component of this responsibility involves establishing a strong rapport with sponsors.

The RC/SW promotes self-advocacy by providing information, training in self-advocacy, coaching, referral, modeling effective strategies and protecting rights. Advocacy is active support which ensures knowledge of and protection of rights and independent exercise/ of responsibility in decision making. Advocacy is based on customer rights and the Woodrow Wilson Rehabilitation Center Shared Values.

Program Variances

Case Managers within WWRC are found in a variety of programs. Each program provides a unique set of services within the milieu of WWRC. As a result, the Case Management provided must take into account the variances in these programs and the needs of the participating consumers. The intent of the Unified Case Management System is to provide philosophical consistency and a core set of forms across the various

programs. It is not to prevent these programs from tailoring the case management provided to the needs of the consumers participating in their own unique programs.

The basic UCM process differs depending on whether the consumer is enrolled in a short term (assessment/evaluation) or a long term (training) program. Throughout the manual, differences will be noted

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SYSTEM COMPONENTS

1. Outreach/Marketing

Assist WWRC in marketing and outreach activities to enhance utilization and improve the pre-admission planning process by:

- ⇒ Visiting field for networking.
- ⇒ Attending professional organization and advocacy group meetings and making presentations to promote WWRC services.
- ⇒ Participating and exhibiting at statewide conferences as an adjunct to marketing.
- ⇒ Assisting in identification of potential employment placements through participation on Occupational Skills Training Advisory Committees and community visits.

(Reviewed 10/0312/08)

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2. Pre-Admission Plan Development Process

Initiate linkage with customer and sponsor prior to admission to ensure service integration through identification of customer and sponsor goals, needs and service availability by:

- ⇒ Receiving and reviewing assigned service authorizations.
- ⇒ Meeting with potential customers upon request.
- ⇒ Providing written and verbal information in order to prepare customers for their Center program.
- ⇒ Providing feasibility consultations.
- ⇒ Contacting customer/sponsor to obtain missing data and clarifying questions raised during pre-admission review.
- ⇒ Establishing preliminary discharge plans prior to admission.
- ⇒ Contacting customer and sponsor to develop a plan of services based on individual needs and outcome goals
- ⇒ Completing Pre-Admission Planning by reviewing background, history, needs, and referral questions. Distributing Pre-Admission Plan to interdisciplinary team members.
- ⇒ Identifying and confirming sponsorship options for requested services prior to admission
- ⇒ Reviewing and identifying needed services and accommodations, confirming their availability, sequencing the services, and planning intervention strategies prior to arrival.
- ⇒ Completing appropriate referrals for other services prior to admission.
- ⇒ Prior to admission, chairing interdisciplinary staffing, as needed, for clients with complex needs., 12/08

(Reviewed 10/03,12/08)
(Revised 12/08)

3. Intake/Orientation/Initial Service Plan Development

Completes intake and orientation process to confirm goals, ensure understanding of service provision, and communicate any additional information to service providers by:

- ⇒ Conducting intake interview with customer and/or family reaffirming customer goals on day of admission or first working day after admission.
- ⇒ Providing information to interdisciplinary team obtained in initial interview.
- ⇒ Addressing initial customer and family concerns and providing feedback.
- ⇒ Coordinating and confirming initial integrated plan across all disciplines including evening services.
- ⇒ Ensuring orientation of student to WWRC and program on day of admission to include scheduling and monitoring student's orientation program, attendance at orientation sessions, and an overview of Center services as well as customer rights and responsibilities.
- ⇒ Confirming customer goals and communicating discharge planning needs and any funding changes to the sponsor.
- ⇒ Reviewing referrals developed in pre-admission activity and ensuring appropriate referrals have been forwarded to service providers.

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(Revised 6/00)

4. Service Plan Review

Leads interdisciplinary service plan reviews through a continuous quality improvement process to ensure appropriateness of the plan, coordination and provision of services by:

- ⇒ Establishing and facilitating an individualized schedule of team meetings throughout customer's program.
- ⇒ Reviewing feasibility of WWRC services with customer, interdisciplinary team and sponsor.
- ⇒ Coordinating interdisciplinary input to establish team goals consistent with the rehabilitation objectives.
- ⇒ Verifying changes in Plan with sponsor; prior to implementation if funding approval required.
- ⇒ Communicating the Plan review results with the family, if appropriate.
- ⇒ Coordinating community integration and employment planning in conjunction with the sponsor, family, and other significant stakeholders.

(Reviewed 10/03)

(Revised 6/00)

5. Provision, Coordination, and Monitoring of Planned Services

Coordinates, refers, and ensures provision of interdisciplinary services and comprehensive rehabilitation program in a timely fashion and according to the Service Plan by:

- ⇒ Initiating referrals not previously identified.
- ⇒ Following-up on referrals to ensure that referral was received and assigned by service line, and completing action required to address untimely responses to referrals.
- ⇒ Ensuring that customer keeps assessment appointments so that assessments can be completed in a timely manner and necessary services are identified.
- ⇒ Following-up on assessments after the completion of the assessment to determine outcome of assessment.
- ⇒ Clarifying and addressing issues initiated by customer, service area, or sponsor.
- ⇒ Assessing financial feasibility for any additional services recommended at the plan review meeting prior to service provision.
- ⇒ Regularly reviewing each customer's progress to determine if goals and objectives are being met, to monitor cost effectiveness of the program, and effectiveness of accommodations provided.
- ⇒ Facilitating team meetings to review modifications of service plans as needed.
- ⇒ Providing assistance, support and resources to the team in the development of behavioral intervention strategies.
- ⇒ Disseminating information to interdisciplinary team.
- ⇒ Monitoring and approving/disapproving all expenditures for customer services and equipment to ensure compliance with sponsor and agency policy.
- ⇒ Meeting with family and/or customer, as requested, regarding issues related to making an adequate adjustment to the environment.
- ⇒ Maintaining ongoing involvement of customer, sponsor, and family, if appropriate, and informing sponsor and family of program status and progress, as appropriate.
- ⇒ Notifying sponsor of leaves/discharges as agreed upon.

6. Counseling and Consultation

Promote the customer's personal responsibility and self advocacy in achieving their individual and rehabilitation goals through an effective communication process which ensures consumer choice through informed consent by:

- ⇒ Providing assessment and instruction in life skills.
- ⇒ Providing individual and group counseling sessions and family interaction in coordination with Psychologists, Mental Health Counselors, and Psychiatrist.
- ⇒ Acting as an advocate for the customer, sponsor, and family.
- ⇒ Developing counseling objectives to include needs, goals, progress, and outcomes.
- ⇒ Counseling with the customer regarding vocational planning and rehabilitation program issues; facilitating problem solving and planning; and consulting with other professionals, the sponsor, and the family.
- ⇒ Adjusting work schedule to meet customer needs.
- ⇒ Assessing self-advocacy needs and developing self-advocacy goals.

- ⇒ Intervening and coordinating resources for crisis situations.
- ⇒ Meeting with each customer on a regular basis and documenting any changes or program issues.
- ⇒ Providing counseling for customer and family regarding community reintegration and employment planning, as needed.

7. Documentation and Confidentiality

Documents all case management and counseling activities such as problem solving decisions and their rationale, consultation given and received, approvals needed and obtained, contacts with others regarding the customer's program, at a level that will allow follow-through in the counselor's absence and which is consistent with WWRC Information and Records Confidentiality policies and procedures by:

- ⇒ Documenting extent of customer understanding of information communicated.
- ⇒ Documenting orientation and instruction to customer regarding WWRC Information and Records Confidentiality policies.
- ⇒ Arranging and documenting customer access to their records when customer request for record review is made.
- ⇒ Advocating maintenance of customer confidentiality and addressing any breach.
- ⇒ Ensuring written informed consent is provided by customer prior to release of information and records.
- ⇒ Ensuring that AWARE transactions are entered into accurately and in a timely manner.
- ⇒ Ensuring that customer information is correct in AWARE.
- ⇒ Generating integrated discharge report, service plans and other forms as required by WWRC Policies and procedures.

8. Community Integration and Employment Planning

Coordinates/implements community integration and employment planning with the customer, sponsor and family as a result of ongoing interdisciplinary team input to address vocational, social, job seeking, independent living skills by:

- ⇒ Assisting the sponsor and customer in locating housing and making referrals to the necessary community resources prior to discharge.
- ⇒ Scheduling and chairing a discharge meeting prior to discharge.
- ⇒ For an unplanned discharge, providing sponsor with information about customer's functional abilities and community integration and employment needs.

9. FOLLOW-UP

Communicates with customer and sponsor to facilitate the success of the community integration and discharge plan, and provides consultation to address any identified issues by:

- ⇒ Contacting customer, family or sponsor after discharge to assess whether discharge plan achieves the goals of the community integration plan.
- ⇒ Addressing any sponsor, family, or customer issues regarding Center or community services, as needed.

- ⇒ Reporting follow-up information to Interdisciplinary Team for their records; and communicating any planning refinements, in the service delivery area, to the Service Line Manager.
- ⇒ Documenting customer and family follow-up information for the chart as needed.

10. Program Evaluation and Outcome Management

The Unified Case Management Steering Committee ensures a unified case management system and the achievement of the case management system goals through measurement of identified efficiency, effectiveness and satisfaction standards by:

Case Management Supervisors - responsibilities:

- ⇒ Reviewing feedback from the Center's Vocational Records Committee which functions as an external quality assurance group.
- ⇒ Developing and implementing consistent and unified program evaluation process.
- ⇒ Using results of audits and observations to review and modify the case management system annually under the direction of the Director of the Customer Services Division.
- ⇒ Hiring, orientation, training, performance planning and evaluation supports achievement of case management service standards.
- ⇒ Consistent application of case management philosophy and policies.
- ⇒ Attainment of goals at or above target levels.
- ⇒ Responding to events that may indicate system breakdown.
- ⇒ Attending plan development, progress review, team and case conference meetings to assure quality planning and service delivery.
- ⇒ Reviewing on quarterly basis three cases (one active; two closed) for each counselor to ensure compliance with established case management standards.
- ⇒ Discussing results of the audits and observations with each counselor to reinforce/ or modify performance.

Rehabilitation Counselor/Social Worker Responsibilities:

- ⇒ Optimize service outcomes.
- ⇒ Ensures timely, appropriate service delivery.
- ⇒ Ensures consistent customer participation, timely response to customer requests and effective facilitation of due process.
- ⇒ Ensures timely, accurate, complete, objective documentation.

(Reviewed 10/03, 12/08
(Revised 6/00)

Chapter 1

Documentation Standards and Expectations

I. Case Documentation

The purpose of case documentation is substantiation of case service activities. Case documentation must provide an ongoing record of activities and among other methods is used by agency auditors and reviewers to help determine case management quality. A great majority of case documentation is required by law (P.L. 102-569, Rehabilitation Act Amendments or implementing regulations). Some of the documentation requirements are agency mandates.

It is important to note that the same thing need only be documented one (1) time. For example, if functional limitations are documented on the Pre-Admission Planning Document (which they must be), they need not be documented in the case notes. Likewise, the information contained on the consumer's Service Plan need not be repeated in the case notes unless the counselors sees a need to do so. Among the methods of documenting a case are the following:

A. Departmental forms

Completed forms provide documentation of case activity. There are numerous agency/center forms, some of which are mandatory, some of which are optional. Among the mandatory forms that provide for a great majority of casework documentation are the Pre-admission Plan, the Service Plan and the Community Integration Plan.

B. Non-Agency-Generated Documents

Letters/memos/reports/bills and responses made to letters/memos, etc., from outside of WWRC should be submitted to Records Management for inclusion in the official record. These provide important documentation of case activity.

C. Case Service Notes

Case Service Notes should reflect information pertinent to a case that was not documented by or on a WWRC form. The purpose is to ensure that accurate information is readily available to other agency staff in the event that the counselor cannot be reached.

II. Service Notes

It is the responsibility of the case manager to ensure that a careful and adequate record of the client's goals, progress/lack of progress, and intervention strategies are systematically recorded. Documentation provides a written account of all significant events and activities related to a client's program at WWRC. Case managers record information in the AWARE Service Note. Documentation will reflect the content, quality, and frequency of counseling/case management services being provided at a level which allows a supervisor or another case manager to assess and continue client services in the case manager's absence.

Standards for Service Notes:

1. Service Notes will be maintained
2. Items included in service notes will include:
 - a) Notation of review of case material prior to the client's entry for program development purposes
 - b) Documentation of topics covered in initial interview
 - c) Recording personal contacts with the client; identifying purpose and decision of the session with reference being made to the client's participation in setting goals in the decision-making process for his/her own rehab program
 - d) Recording telephone and /or personal contacts with sponsor, family other agencies or individuals and center staff of any discussion which may affect a case manager's decision and/or the eventual outcome of a client's program
 - e) Documenting any meetings, such as plan developments, progress reviews, case conferences. Case note entries can refer to minutes when taken/. Otherwise, detail of meetings must be included in the case notes.
 - f) Explaining why any previously recommended service is or was not being provided as part of the program
 - g) Recording any process where the case manager and his/her supervisor review case material and goals. This also includes any decisions made by the supervisor on items which require prior approval
 - h) Describing services and plans as reviewed with the client during the discharge planning meeting
 - i) End of service notes. When a case manager leaves his/her position or transfers a case to another case manager, a summary of the case must be included in the case notes. Notes must include overall progress, reasons for decisions, and counseling/case management issues which need follow-up.

(Reviewed 11/3/03
(Revised 11/3/03, 12/08)

II. Unified Case Management Standards and Expectations (Long Term)

| | |
|--|--|
| Pre-Admission Planning | |
| Pre-Admission Plan with Preliminary Community Integration Plan completed two (2) working days prior to admission) | |
| Referrals made if applicable two (2) working days prior to admission | |
| Intake/Orientation/Initial Service Plan Development | |
| Intake Interview and/or Meeting conducted day of admission or first working day after | |
| | |
| Plan Review | |
| Plan Review, including on-going assessment of Community Integration Plan, completed with input of Interdisciplinary Team (Case Manager, Sponsor, Person Served, and all Service Providers) within first month. | |
| Changes to Plan communicated to sponsor and/or family as needed within two (2) working days | |
| Monitoring of Planned Services/Progress Reviews | |
| Progress reviewed with client and summarized in case notes at regular intervals and team meetings held as necessary to address problem areas. | |
| Notify sponsor or sponsor's supervisor of all leaves (over 5 working days), Discharges & Program Changes and record in service notes. | |
| Counseling and Consultation | |
| Meet with Client regularly, at least once every 30 days and record in case notes | |
| Documentation & Confidentiality | |
| Census transactions completed within 1 working day of time of transaction | |
| Rights and Responsibilities explained to consumer and agreement indicated by signature on day of admission | |
| Signed releases obtained for any release of information prior to releasing information record in case notes | |
| Discharge Report generated within 21 calendar days of discharge | |
| Community Integration & Employment Planning | |
| Team Meeting to develop Final Community Integration Plan 45-60 days prior to anticipated discharge | |
| Final review of Community Integration Plans completed prior to discharge | |

(Reviewed 10/03)
(Revised 6/00, 12/08)

Pre-Admission

I. Regional Teams

The Counseling Department is divided into four (4) teams. Each team is assigned a region of the state corresponding to the DRS Field Office Regions. The purpose of this configuration is to enable Case Managers to focus on a specific geographic area in order to develop closer working relationships with a limited number of referral sources and to tailor programs, services and recommendations for the resources and the job market in that specific area. These teams are responsible for the quality and quantity of referrals from their respective region, for managing the case during enrollment and for the employment outcomes after discharge.

II. Networking/Staffing

As dictated by the Unified Case Management Philosophy Document, the Counseling staff is expected to be available to referral sources for review and consultation on an as needed basis. Referral Sources are encouraged to utilize this capability whenever the need arises. Counselors network with major referral source, the DRS Field Offices, whenever possible at conferences, workshops and training programs as well as through individual visits to the various offices from time to time. Additionally, the counseling department management participates in the WWRC Business Development process. Through these activities, opportunities frequently arise to staff individual cases and provide consultation to the referral sources when questions develop regarding feasibility or outcome potential.

III. Pre-Admission Review Process

The Admissions Department is responsible for receipt and initial screening of, applications for WWRC Services as well as acceptance determination and scheduling. As determined by pre-set criteria, applicants may be accepted and scheduled for services prior to case manager review. In these instances, referral information is delivered to the counseling department for assignment to, and review by, a Case Manager.

In instances in which the Pre-Admission Technician is unable to determine feasibility for services, when dictated by the severity of the disability or the complexity of needs; the referral information is forwarded to the counseling department prior to an admission decision being made. The regional team assigned to that individual's geographic region provides for review of the case material and input into the decision making process.

In any event, during the pre-admission review process, the case manager must: review background material, contact the referral source, contact the consumer if indicated, convene a pre-admission planning meeting with the interdisciplinary team if indicated, and enter into the formal Pre-Admission Planning process to include development of intervention strategies.

a) Policy on Pre-Admission Review of Clients Needing Special Accommodations

OBJECTIVE: To identify and provide effective pre-admission/pre-transfer planning for clients with special accommodation needs so that full program participation can begin upon admission to their vocational program.

POLICY: It is the policy of WWRC to provide effective, comprehensive pre-admission planning and service procurement for all clients being enrolled in rehabilitation programs.

PROCEDURES:

EXTERNAL ADMISSIONS:

| ITEM | STAFF RESPONSIBLE | ACTION |
|----------------------------------|--|--|
| Center Referral | Pre-Admission Technician | Processes referral in routine manner and decides if client is feasible for WWRC services. If has a question regarding feasibility, collaborates with the designated vocational counselor or other appropriate professionals, as needed. |
| Identification | Pre-Admission Technician | Uses pre-screening checklist to determine clients who potentially may need special accommodations and more than routine pre-admission planning. |
| Identification | Pre-Admission Technician | If identifies a residential medical client whose rehabilitation plan is to move into a vocational program after receiving the medical services, consults with Pre-Admission Technician to pre-screen client and determine if assignment of designated vocational counselor is appropriate. |
| Designated Vocational Counselors | Counseling, Vocational Evaluation, and HTP Program Supervision | Counseling Supervisor will designate vocational rehabilitation counselors who will work with all clients who are anticipated to enroll in vocational services involving more than a vocational evaluation regardless of entry point into the system. The counselors will take cases on an alternating basis according to admission date. (i.e.-every other case) However, all DVH and deaf/hard of hearing clients will go to the designated specialty counselors for those populations. The HTP Program Supervisor completes all of the pre-admission planning for HTP clients. |
| Consultation | Pre-Admission Technician | Determines if client is to only receive vocational evaluation services or if he/she is likely to receive more extensive vocational services. Contacts appropriate designated vocational counselor and requests chart review. If feasibility is in question, asks designated vocational counselor to provide input on that decision within 48 hours. |

| | | |
|---------------------------------|--|--|
| Pre-admission Planning Decision | Designated Vocational Counselor/HTP Program Supervisor | Reviews case identified and determines if special accommodations and more than routine pre-admission planning are required. This review will be done within 48 hours. (If the review can not be completed within 48 hours, counselor will contact Pre-Admission Technician and let him/her know when the review can be completed.) If additional planning is not needed, counselor will document in pre-admission contact notes and return case to vocational admissions for routine processing. If feasibility is in question, communicates with Pre-Admission Technician on that issue so that a joint decision can be made. |
| Sponsor Contact | Pre-Admission Technician | If additional planning is not needed, sponsor will be contacted according to routine procedures. If designated vocational counselor can not complete chart review within 48 hours, contact sponsor to let him/her know that case is being processed. |
| Pre-admission Planning | Designated Vocational Counselor | Determines all equipment and services that are needed to be in place upon enrollment, using the expertise of internal staff as needed (ex. CAL team, OT, PT, Communications Services, vocational lead teacher, etc.). A team planning meeting may be required to determine all needs. All pre-admission needs will be listed in the pre-admission contact notes. Person responsible for securing needed services and target completion dates will be identified for each. Funding options for any needed equipment will be determined and equipment will be procured, as needed. Copies plan in pre-admission contact notes and sends to Pre-Admission Technician, if keeping the chart. |
| Admission Date | Pre-Admission Technician | Schedules all services assigned to Admissions in the plan using tentative completion dates and determines a tentative Center admission date. Tentative date will be confirmed with designated vocational counselor to ensure that the rest of the services can be in place by that date. Once the date is agreed upon by Admissions and Counseling, the routine admissions procedures will be followed. |
| 3 month Verification | Designated Vocational Counselor | If 3 months or more elapse, between pre-admission planning initiation and the date of actual admission, contacts client to see if needs have changed. |
| Plan Coordination | Designated Vocational Counselor | Continues to coordinate and follow up on program development and service procurement. Returns chart to Admissions 1 month before scheduled admission date. |

Post-admission
Case
Management

Designated Vocational
Counselor

Continues to provide counseling and case
management throughout the client's entire program
at WWRC.

(Reviewed 10/03, 12/08)
(Revised 6/00)

c) Pre-Admission Plan Development

| ITEM | RESPONSIBILITY | STANDARD |
|---|-----------------------|---|
| Case Assignment | Department Supervisor | Assign case per departmental procedure (Currently Regional Team. |
| Case Review | Case Manager | Complete review to document background, history, needs. |
| Linkage with consumer and sponsor | Case Manager | Contact client and sponsor to clarify referral questions and further assess needs |
| Pre-admission Team Meeting (if indicated based on severity of disability and complexity of needs) | Case Manager | Include all anticipated service providers, referral source, person served. |
| Pre-admission Plan | Case Manager | Written pre-admission plan at least two working (2) days prior to scheduled admission date. |
| Pre-Admission Referrals | Case Manager | Complete referrals for assessments/treatment needs as identified by the Pre-admission Plan. Distributed prior to scheduled admission date if indicated. |

Outcomes

- 1) Clarification of referral questions
- 2) Assessments of needs/goals/capabilities
- 3) Completion of Pre-Admission Plan
- 4) Verification of sponsorship
- 5) Preparation for entry
 - Assessment of needs/goals/capabilities and determination of risk status
 - Initiation of planning for Community Integration and determination of community reintegration goals.
 - Verification of availability of needed services as identified by Pre-Admission Plan

(Reviewed 10/03, 12/08)
(Revised 6//03)

Intake and Orientation

I. Intake/Orientation/Initial Service Plan

| ITEM | RESPONSIBILITY | STANDARD |
|------------------------------|----------------|---|
| Intake Interview/Orientation | Case Manager | Complete Intake interview day of, or first working day after admission. |
| Service Plan | Case Manager | Review with Person Served on day of intake. |

Outcomes

- 1) Determine immediate needs of Person Served in response to the center environment.
- 2) Identify goals of Person Served at intake.
- 3) Complete orientation and Rights and Responsibilities
- 4) Assure attendance at mandatory General Orientation
- 5) Review Pre-Admission Plan and anticipated service needs.
- 6) Reflect changes and input of Person Served in Service Plan
- 7) Review and update preliminary Community Integration Plan.
- 8) Generate referrals to service providers as needed.

(Reviewed 10/03)
(Revised 6//03, 12/08)

II. Orientation

The Case Manager provides an Orientation overview at time of intake interview and monitors the person served's participation in the general centerwide orientation program. The emphasis during orientation is on responsibilities and rights, adjustment to the residential environment, preparation for independence and community integration. Orientation may be accomplished as an individual and/or group process and the person being served acknowledges his or her participation and understanding by signing the orientation sheet which is removed from the Student Handbook and forwarded to Medical/Vocational Records.

(Reviewed 10/03)
(Revised 6//03, 12/08)

Plan Development

The DRS Employment Plan (IPE) is the guiding document for all services provided by WWRC. Therefore, consistent with DRS Policy and Procedures:

- ♦ The Employment Plan and any substantial amendments shall not be implemented until the counselor and individual (or individual's representative, as appropriate) agree and sign the Employment Plan and any substantial amendments (*Federal Regulation 34 CFR § 361.45*); and

- ◆ Any change of program area, progress measures or employment goal will result in a substantial amendment.

“Woodrow Wilson Rehabilitation Center (WWRC) counselor shall participate (but is not required to sign the Employment Plan or substantial amendment) when the consumer is at WWRC.... If it is not feasible for the field counselor to travel to WWRC for Employment Plan development, the field counselor may lead the development process via conference call with the WWRC counselor and individual actively participating in the process.

- i. The WWRC and field counselors shall coordinate to obtain any accommodations needed (i.e., interpreter services, attendance of the individual’s representative, etc.) to enable the individual to understand and actively participate in the Employment Plan development process.
- ii. If there is disagreement regarding the rehabilitation program or Employment Plan content, the field counselor shall determine whether an on-site meeting at the Center is needed or whether the individual should return home before services are provided.
- iii. The field counselor and WWRC counselor shall each maintain a copy of the Employment Plan. “

Therefore, it is the responsibility of the WWRC Case Manager and the Rehabilitation Team to address the issue of an amendment to the plan when all parties have agreed upon a substantial change. The DRS Field Counselor, with assistance from the WWRC Case Manager, will be responsible to ensure that an amendment is completed in within 3 working days of the decision; and that signatures are obtained as required.

(Reviewed 11/3/03, 12/08)
(Revised 5/30/00)

III. Community Integration

Community Integration Planning begins during the pre-admission phase and continues throughout an individual’s enrollment. The preliminary plan is formed based on referral information and telephone contacts with the Person Served, their family, and/or the sponsor. This plan is updated at intake during face to face contact. These plans are kept at the forefront during progress and team meetings throughout the enrollment period, then finalized prior to discharge during the Discharge Planning Meeting with the input and assistance of the person served, the Employment Coordinator and the sponsor in the community.

(Reviewed 11/03)
(Revised 11//03)

Chapter 4

Provision, Coordination and Monitoring of Planned Services

I Progress Review

Timely and frequent progress reviews are essential to providing a quality service. This enables early intervention to be provided when progress is not meeting expectations.

- A. Progress Review Team Meetings: Frequency of team meetings for the purpose of progress review will be determined at the time of the Plan Development Meeting to accommodate the anticipated needs of each individual consumer. A Progress review Team Meeting can be requested by any team member as the need arises. Requests will be directed to the Case Manager for the meeting to be scheduled and coordinated. All team meetings will be adequately documented either in the case notes or via formally recording the minutes and will include persons attending, purpose of the meeting as well as results and action to be taken.
- B. Progress Summary: Each 6-week period, the instructor will complete a progress review indicating the consumer's current status in the training program, tasks completed, etc. This Progress Review will be sent to Medical/Vocational Records to be placed in the consumer's chart. A copy will be sent to the Case Manager. The Case Manager will then complete the Progress Summary addressing progress in all areas of the center program as well as any changes or additions that may need to be made to the service plan. The progress summary will be documented in the case notes and reviewed with the consumer.

C. **Client Performance And Progress WWRC Policy 5.10**

It is the policy of Woodrow Wilson Rehabilitation Center to provide the necessary supports needed by a consumer to achieve program goals. Likewise it is Center policy to expect performance and behavior appropriate to vocational goals and independent living. Consumers may expect reasonable and timely response to needs. Consumers are expected to attend and participate fully in support services and primary service programs. In addition, each consumer is expected to comply with the WWRC Standards of Conduct. These expectations will be made clear in the orientation and program planning process. All service providers making up the Rehabilitation Team will provide the consumer regular and thorough information regarding achievement and any need for change. The information shall be provided in the manner needed for the consumer to make fully informed decisions about their program. In the event of unsatisfactory progress, the consumer will meet with his or her rehabilitation team to determine changes needed and to develop strategies for improvement.

WWRC services can be terminated short of program completion for reasons including, but not limited to:

- Serious incident determination;

- Absence from the Center with no prior notification or subsequent contact for a period of three or more days;
- Self termination, a consumer's decision to discontinue with a program at WWRC; or
- An opinion on the part of a physician that the consumers' medical stability is such that continuation of enrollment will result in potential harm to self or others.

Further, the Rehabilitation Team will meet to consider termination of a consumer's WWRC program if:

- He or she declines to accept or participate in services determined by the team to be critical to the achievement of an employment outcome or maintaining medical and/or psychological stability;
- A pattern of absenteeism in the primary program exceeds 10 percent;
- A pattern of failure to appear for appointments with service providers is displayed;
- A pattern of failure to achieve adequate progress in the planned program, and/or
- Inadequate resources to provide the level, intensity or complexity of services needed to achieve effective progress in the planned program.

In the event of continued unsatisfactory progress or application of effort, the consumer and rehabilitation team will meet to determine the status of the consumer's program. This may include: (1) the addition of further support and accommodations considered likely to improve performance, (2) further evaluation to revise program goals, or, (3) termination of the consumer's program as infeasible under current circumstances. Termination from Center Services may occur immediately upon determination of infeasibility in which case it is the expectation of the Center that the consumer will vacate the grounds immediately.

In the event of disagreement with the team decision, the consumer may immediately request an administrative review of the team decision from the appropriate program supervisor. The supervisor may: (1) return the decision to the team with recommendations, or (2) uphold the team decision, informing the consumer of the reason for the decision and the time frame within which the termination will take place. In addition, the supervisor will inform the consumer of his or her right to a fair hearing, to occur following discharge from the Center.

(Revised 12/2000, 12/08)

(Reviewed 11/3/03)

II Guidance and Counseling

A. General Concerns

Counseling and guidance services are those services provided at any stage of the rehabilitation process when a consumer is consulted with and advised in regard to functioning successfully in a vocation. Problems and potentials of the consumer are considered. Regular contacts are crucial if emerging problems are to be identified and solved.

Counseling and guidance services are used as follows:

1. In the development of a program for reaching a suitable vocational goal.
2. As a part of each service program.
3. As a means of developing a mode of behavior that can assist in achieving success in a vocation.

Counseling is vocationally oriented which differentiates vocational rehabilitation counseling from other types of counseling efforts.

Counseling should address the consumer's social and personal adjustment problems, insofar as these problems affect vocational adjustment. While counseling techniques may assist the consumer to modify basic attitudes that resulted in maladjustment, it is primarily for the purpose of enabling a vocational process to occur.

The provision of counseling and guidance is not subject to a determination of economic need.

B. Definitions

1. COUNSELING is a term generally accepted to indicate an interaction with a consumer wherein the consumer receives assistance in coping effectively with important issues or concerns, in developing plans and making decisions, in exploring feelings about self and significant others, in changing ineffective behaviors to more effective behaviors, and in making an adequate adjustment to the vocational environment.
2. GUIDANCE is a term generally accepted to indicate a qualitatively different interaction with the consumer wherein the counselor serves as a giver of information, a coordinator, and advocate, or as a mediator.

C. Ongoing Counseling and Guidance

Establishment of a professional counseling relationship with a consumer is the foundation for providing the other services necessary to achieve successful employment. Within the counseling relationship, and throughout the rehabilitation process, ongoing counseling and guidance might include but is not limited to:

1. A general overview and explanation of the VR process including the eligibility process and the 60 day time frame for determining eligibility.
2. Research into possible third-party benefits.
3. An explanation of the consumer's rights and remedies, including the consumer appeals process and the CAP program.
4. Discussion of information necessary to document eligibility.
5. Identification of specific vocational strengths and limitations, other barriers to employment, goals, and resources.
6. A discussion of possible job placement options and an initiation of tentative job placement plans.
7. An exploration of the consumer's attributes including:
 - a. Perception of rehabilitation needs, employment goals, disability and functional abilities and limitations.
 - b. An assessment of the consumer's motivation and a discussion of realistic vocational goals.
 - c. An assessment of the consumer's education, employment history, skills, stability, family support, financial assets and comparable benefits.
 - d. As assessment of the consumer's transportation, housing and leisure time needs.
8. A discussion of ineligibility information.
9. Counseling regarding extended evaluation including the reasons for undertaking.
10. Information and guidance on self-advocacy.

11. Counseling to review available information and to develop a vocational goal/plan.
12. A joint discussion of vocational alternatives/options.
13. Counseling to explain the consumer's responsibilities and role in the rehabilitation process and the objective criteria to be utilized to determine progress towards achieving established goals.
14. Counseling regarding the need to gather financial information.
15. Counseling to assist the consumer in understanding and following medical advice.
16. Discussion about the availability of support services.
17. Counseling regarding adjustment to a training facility and information regarding the requirements and rules of the facility.
18. Information regarding employer expectations including attendance, sick leave, staying on task.
19. Information regarding salary expectations.
20. Information regarding appropriate dress, hygiene, and behavior.
21. Information regarding job modification and attitudinal barriers.
22. An understanding of case termination and the conditions of the closure process. An explanation of post- employment processes and the reopening of a case.

D. Request for Counselor Change

Clients may request a change of case manager through the case manager's immediate supervisor. The following steps will be followed:

1. Request appointment with case manager's immediate supervisor
2. Meet with the supervisor to discuss the issues which led to the request
3. The supervisor, if he feels the issues are relevant, may then schedule a meeting between the client and the counselor to assure the issues are understood by both parties and to attempt to reconcile differences
4. The supervisor will then, in consultation with both parties determine the need for a transfer of case management.

The client may, at any step of the process, discontinue the process and appeal to the next level manager or may institute the formal DRS Fair Hearing Process.

III. Financial Management

A. Review of a Client's Financial Condition

It is the responsibility of either the WWRC Case Manager or the DRS Field Counselor to conduct an annual IPE review with each client. The responsibility of this review will be negotiated on an individual basis. At the time of this annual review, a reassessment of the client's financial situation will take place. The case manager has the authority to review the financial condition of a client at any time during his/her program when the case manager feels such a review is necessary and in line with the DRS Policy Manual on financial eligibility.

(Reviewed 10/03, 12/08)
(Revised 6//00)

B. Prior Approval Requirements for Purchase of Goods and Services

| | |
|-----------------|-------------------|
| < \$500 | Counselor |
| \$501 - \$2,000 | Lead Counselor |
| > \$2,000 | Division Director |

(Reviewed 10/03, 12/08)
(Revised 8//05)

IV. Miscellaneous

A. Laundry & Incidental Money

L & I represents agency funds which have been designated as part of maintenance for DRS clients to help them with personal expenses (such as laundry, personal hygiene items, travel, etc.) while enrolled in a residential, rehabilitation program.

It is the intent of the L&I program that it is to be utilized only as a last resort for those students who have no other form of income or financial support.

To be eligible to receive L & I, the individual must:

1. **Be** enrolled as a residential student prior to the day money is issued.

2. **Be** fully enrolled in a Training or Pre-Vocational Training program.
3. **Be** sponsored by DRS for at least part of the maintenance costs.
4. **Be** present at the center at least one day during the week.
5. **Not** be a participant in the WWRC Financial Participation Program. If the student's family is paying any part of the cost he/she is **not** eligible for L & I.
6. **Not** be a recipient of Social Security benefits. (This could include SSI, SSDI, or as a survivor who is eligible for "student" benefits).
7. **Not** hold any paying job while at WWRC.

An individual is **not** entitled to advance payment except by written notice from the Supervisor of Counseling. An individual is **not** entitled to retroactive payment unless student met the above criteria for the week in question, **and** was unable to pick up the money through no fault of his/her own. When requesting retroactive payment, the Case Manager must provide clear and detailed justification as to the reason.

Eligibility is determined by the Case Manager and indicated via email to the cashier. Any changes in the eligibility status must be communicated immediately by the Case Manager also via email.

Staff may not sign or accept L & I for a client.

(Reviewed 11/3/03, 12/08)
Revised 1/31/03)

B. Wheelchair Rentals & Repairs

Rentals:

1. Rental form is initiated by physicians, either on the units or in Student Health.
2. PT then prepares specifications, arranges for type of chair, attachments required and prepares the Wheelchair Rental Form.
3. The chair is delivered to Central Storeroom, logged as to identifying chair number, serial number, client's name, and delivery date before being delivered to PT

(Reviewed 6/03)
(Revised 6//00)

C. Safety Glasses, Tools, Books, Uniforms & Clothing

WWRC Policy on Clothing Purchases

When a DRS client is accepted for admission at WWRC, he/she receives a DRS policy allows the purchase of clothing if needed for training or for employment. Traditionally, WWRC has routinely provided funds to our clients to purchase appropriate clothing if needed for participation in training programs and/or to participate in a job interview. In order to maintain fiscal prudence, WWRC will no longer provide funds for this

service except in very rare and exceptional circumstances. Prior to enrollment in WWRC, the consumer receives a letter confirming the scheduled date. Included in that letter is a list of recommended clothing and other items that will be needed. It will be the responsibility of the consumer in conjunction with the FRS Counselor to review this list and make arrangements to obtain items that may be needed. Any consumer indicating a need after being enrolled will be directed to the WWRC Clothes Closet. If no suitable clothing is found, he/she will be assisted in contacting the field counselor to discuss the matter.

(Reviewed 11/3/03)
(Revised 7/8/99, 12/08)

Books, Tools, Uniforms

The Employment and Occupational Skills Training Department will issue tool kits to appropriate clients enrolling in vocational training. When an instructor desires books, uniforms, safety shoes, etc., for his clients; he/she will choose the appropriate training supply form and forward to the storeroom. If additional uniforms, tools, etc., are necessary, the training instructor will contact the case manager who will determine if the client or sponsor is financially responsible. If DRS is financially responsible, the instructor will prepare a training supply form. The case manager will also obtain an IPE amendment. When the client is responsible, the instructor must indicate such on the training supply form. The client will take the training supply form with appropriate money to the Business Office for a receipt. He/she will take the receipt and training supply form to the Training Storeroom to pick up specified item(s).

Tools upon Completion:

Form RS-14 (262-02-032), Title of Agreement, Occupational Tools and/or Equipment is completed when any tool or piece of equipment issued to a client costs over \$100.

(Reviewed 6/03, 12/08)
(Revised 6/00)

D. Authorizing Payment for Nurse's Aide Competency Test

The instructor will complete a test application and notify the case manager to prepare an RS-6. The instructor will take the application and RS-6 to the WWRC cashier's office to have a check prepared for the Psychological Corporation of Texas. The instructor will mail the check and application. The WWRC cashier will post the charge to the student's account.

(Reviewed 11/03)
(Revised 6//00)

E. Charging SIP Students

REGULAR: Students enrolled in SIP will be charged the basic per diem rate for Vocational Training and will remain on the Training shop roll.

STATEWIDE: Students enrolled in the Statewide SIP will remain enrolled in the Training shop and billed a one-time charge of \$750 by the case manager and then placed on leave.

If a student has been discharged from the Center and the sponsor requests a Statewide SIP, then the student is enrolled as an outpatient, billed a one-time charge of \$750 by SIP coordinator, and ~ then placed on leave.

(Reviewed 11/03, 12/08)
(Revised 6//00)

G. Suicide Protocol

POLICY: Center staff shall respond to situations when it appears that a consumer has made a suicidal attempt or gesture or threatens to harm himself/herself.

PROCEDURES: Consumer should be taken immediately to Student Health where the Nursing Supervisor will evaluate the situation. The Nursing Supervisor should contact the clinician on call regarding treatment or disposition, including the use of one-to-one supervision in Student Health. When appropriate, a contract should be initiated with the consumer.

Psychological Services staff will provide an assessment.

Any time a client appears to remain actively and seriously suicidal, the consumer should be kept under constant supervision while arrangements are under way for transfer to a psychiatric hospital.

When a consumer is taken to Student Health for a suicidal gesture or attempt, the case manager will call a team meeting within 24 hours. The team will decide if the consumer's program will continue and if so will develop an individualized intervention plan according to the established format.

(Reviewed 11/03)
(Revised 6//00, 12/08)

I. Suspected Sexual Assault

Any consumer reporting to a staff member that he/she has been sexually abused or assaulted should be referred to Student Health. The duty case manager or appropriate case manager should be notified immediately. Once in Student Health, staff will obtain the history of the incident and notify the physician on call. The physician on call may either check the consumer directly or direct the nurse to send the consumer to a nearby hospital emergency room for examination and follow through. This examination should be done within 72 hours of the alleged incident. It will be the responsibility of the emergency room to notify the appropriate legal authorities. The case manager should notify Center Administration (Director or Chief of Staff) of the incident.

(Reviewed 11/03)
(Revised 6//00)

J. Dental Policy

Dental Treatment Procedures

WWRC Policy allows for the provision of minor dental treatment (defined as a simple filling or extraction) for the relief of pain that prevents a student from participating in his or her training program.

WWRC funds, however, are used only as a last resort and it is the expectation that the WWRC Case Manager has thoroughly investigated all other sources of funding prior to expenditure of WWRC funds. Therefore, the following procedures will be implemented effective immediately.

1. As always, a consumer is welcome to pursue dental services through his or her own resources at any time. However, due to the confusion that often arises over issues of fees and funding sources, the consumer is obligated to initiate the contact with the dental provider to schedule appointments or for inquiries regarding cost of service.
2. The following procedures will apply when the service is to be authorized directly to the vendor by the DRS Field Office or when the appointment is to be funded by WWRC.
3. Fees will be based on those listed in the FRS Services Reference Manual available through the following link <http://intranet/drs1/frsservicesmanual/>.
4. In order to assure equitable distribution of referrals to the community providers, the Manager of the Case Management and Counseling Division will designate a staff person to compile and maintain a list of providers who have indicated a willingness to accept fees, and will assure referrals are made on an equitable basis.

Procedure:

1. Case Manager becomes aware of consumer's complaint, completes and mails Uniform Referral Form to Student Health for assessment and recommendations relative to dental pain. Student Health physician initiates prophylactic treatment if needed and indicates if further dental treatment is needed.
2. Case Manager meets with student, and determines if pain is such that it prevents the individual from adequately participating in the rehab program at WWRC. Generally, those in short term evaluation programs will be able to obtain dental treatment in their home community following completion of the WWRC program
3. Case Manager discusses consumer's ability to pay and to access dental services in home community.
4. If consumer does not have the financial resources or third party payment, case manager contacts FRS Counselor and together they develop a plan which will include whether the service will be accessed in the home community or in the WWRC local community.
5. If service is to be provided in the local WWRC area, the case manager and FRS counselor determine method of payment (Direct authorization from FRS Office to local provider or authorization by WWRC to local provider).
6. WWRC Case Manager submits request for approval via email to Manager, Case Management and Counseling Division. Request will include justification of need to receive treatment, need for DRS/WWRC to fund the service and reason service cannot be provided by consumer's dental provider in the home community.
7. The Case Manager and Counseling Division Manager will respond within 24 hours with approval/disapproval and will copy Program Support Technician assigned to Case Manager.
8. If approved, Program Support Technician contacts designated staff person to obtain provider information, contacts provider to arrange appointment and to coordinate payment process; and notifies Counseling Department Receptionist to schedule transportation if needed.
9. The case manager notifies the Student Health Office Services Specialist via email of the plan and the subsequent outcome of services.

(Reviewed 11/3/03)
(Revised 8/15/03)

K. Vision and Eye Glasses

The case manager can authorize a client's eye exam by sending a referral to Student Health. The referral should state the nature of the problem and any other pertinent information.

If indicated, the case manager may authorize examination and glasses with cost not to exceed DRS allowable fee . If the client requests glasses at a higher cost, approval from the sponsor and the case manager's supervisor must be obtained. The client can arrange to pay the vendor for amounts exceeding those authorized by the case manager. Safety lenses can be authorized.

(Reviewed 11/03)
(Revised 2//91, 12/08)

L. Class Absences

1. Vocational Training:

a. Absences:

When a client is absent from class, the instructor will notify the case manager verbally or by way of the Vocational Training Absentee Report. The Vocational Training Absentee Report will be sent from Training to the Counseling Department and the dormitory daily by 8:30 a.m. The Dormitory Counselor on duty will check on any and all consumer's indicated as being absent for reasons unknown. Their findings will be communicated to the case manager.

(Reviewed 11/03, 12/08)
(Revised 6//00)

M. Passes

Case manager action: planning, counseling, clerical & case recording

Only those clients in a level I or Level 2 Residential status are required to obtain a pass.

Passes are given at the discretion of the client's case manager who issues passes according to the expressed desire of the client and governed by the status of the individual in his/her program. Copies of passes are sent to the client's housing area, and a record of pass usage is documented by the case manager or designee. The case manager should stress during intake and orientation how he/she plans to handle passes and what to do in case of emergency.

In making judgments to authorize passes, the case manager must consider:

1. Client's age (under 18 or legal guardianship means the client's guardian or parent must approve permission to be away as indicated on Permission Form.)
2. Client's plans and how they might medically or psychologically affect client's rehab program.
3. Client's previous experiences while on pass.
4. Any limits set by case material and/or sponsor.

Client should understand his/her responsibilities while on pass which are outlined below:

1. Obtain a written pass before you leave the Center. Passes may be obtained from your case manager, or in his/her absence, from the Night Counselor or Residential Services case managers.
2. Clients under the age of 18 must have a pass permission slip (Form #26) filled out by the parent or guardian in order to be eligible for passes and/or Center-sponsored recreational trips.
3. Turn in passes to housing areas as soon as you return to the Center as they are no longer good, and we need to know you have returned
4. In order for your therapy and/or training to be effective, you need to attend regularly. Permission to be away from the Center during times of your scheduled activities will be cleared in advance.
5. If a pass is misused or if social conduct has been reported to be inappropriate at the Center or away on pass, the pass may be cancelled.
6. Walking passes for clients in the most restrictive housing option can only be written for bona fide therapeutic reasons. Passes must be obtained on a day to day basis from the student's case manager, Student Health, or Psychological Services
7. Clients socialize in designated recreational areas and follow the social rules in each area. To visit a client who lives in the Nursing Services Unit, first you must get written permission from Your case manager.
8. Case managers can write passes for the recreational building during daylight hours if a client is excused from work.

When family members visit unexpectedly, the night duty case manager or dormitory case manager has the authority to issue passes if the client's case manager cannot be reached. Case managers who work the evening program do not approve passes, as it is the client's responsibility to plan ahead for time away from the Center with the respective case manager. Emergencies are handled on an individual basis.

Clients in the least restrictive residential option and the monitored residential option are not required to obtain passes. The following guidelines apply:

a. Least restrictive:

Walking privilege - Two areas have been designated for walking/jogging privileges. These are the lake area and a square of country road directly north of the Maintenance Department. During the daylight hours, clients can walk/jog off campus and in any of the designated areas. Clients need to sign out at either the dorm offices or client receptionist's desk. After dark, clients can walk around the quadrangle within the complex. From 1:00 a.m. - 6:00 a.m., clients can walk in the areas of the self-management (Option I) lounge to the Women's Dorm lobby.

Curfew - There is no curfew; however clients need to abide by quiet time rules.

Coming and going from the Center - When leaving the Center, clients need to sign out and in. The sign-out books will be located in the dorm offices and will include name, date, and approximate time of return.

b. Monitored:

Walking privileges - Sign-out procedures similar to Option I with walking/jogging limited to the on-campus routes.

Curfew - Curfew will be at 11 p.m.

Coming and going from the Center - Clients will be able to sign out until 12:00 midnight.

(Reviewed 11/3/03)
(Revised 2/23/01, 12/08)

N. Leaves

1. General

Leaves may be recommended by the case manager, sponsor, Center physician or psychologist due to illness, personal or family problems, or other legitimate reasons. Only the case manager has the authority to place a client on leave with notification of sponsor. It is expected that 15 days is sufficient leave for all situations except hospitalization and disciplinary suspension. If the 15th day falls on a Friday, Saturday, or Sunday, the client may return on Sunday night or Monday morning Prior to class time.

All dormitory clients going on a 15-day leave will deposit the room keys and name tag in the box on the dorm and may be requested to make the room available for another client by removing all or part of the personal belongings. Arrangements for taking, packing or storing personal belongings will be made between the client and the residential hall coordinator.

2. Extended Leave

After 15 days on leave, clients will automatically be terminated unless a written request for extension has been approved. Requests for such extensions may originate with either the case manager or the sponsor. A written memo to the case manager's immediate supervisor is necessary for approving leave extensions from the 16th to the 30th day. No leave will be granted beyond 30 days. On the 30th day, the client will be discharged regardless of the reason. If there is a definite date to return in the future, an advance date can be obtained. The residence area, non-originating case manager and all departments in which the client is involved will be given written notice of approved extensions, including the length of the extension.

If the case manager learns the client is not going to resume Center services, the case manager will discharge the client and notify the residence area and all other involved departments. The sponsor will be notified. Arrangements for retrieving any personal belongings stored at the Center will be made jointly by the client and case manager. The case manager will notify the residential hall coordinator or SLS coordinator of the arrangements made.

After discharge, if a client wishes to return to the Center, regular admission procedures must be followed.

3. Failure to Return from Weekend Pass

When a client does not return to the Center from a weekend pass for the regularly scheduled program, the client will be considered AWOL and unexcused beginning that day.

Note: If a client leaves for the weekend on Friday and does not return to resume the program by Monday, the client cannot be counted absent without leave for Saturday and Sunday, since a pass granted permission to be away from the Center on those days.

The client will be placed on leave as of the day he/she was to report for his/her program of services but did not appear, and the sponsor will be notified. Within five days, the case manager will, if possible, determine the cause for the absence without leave. If the case manager determines within that time that the client has a legitimate reason for not returning to the Center, the client's date to return from leave will be finalized. If for any reason the client will not return to the Center to resume services, discharge will be effective the day client was placed on leave, and sponsor will be notified.

4. Failure to Return from Leave

If a client does not return within seven days of the anticipated date of return, the case manager will determine the client's status. If an extension is not warranted, the client will be discharged on the date that he/she was placed on leave, and the sponsor will be notified.

(Reviewed 5/05)
(Revised 5//05, 12/08)

O. Transfer of Non Residential (Day Student, Outpatient, Statewide ETO) Status to Residential Status (Dorm, SLS)

In order for a Case Manager to transfer a client from a non-residential status to a residential status, he/she will consult with the Admissions Department. The Admissions Department will review the information and required paperwork and advise as to any additional information, applications, consents, etc that may be required as per the admission policy. Admission staff will also review the background information to determine if the Admission Policy/Criteria is met. Review by other disciplines such as Student Health, Behavioral Health, etc. in addition to review by the Admissions Committee may also be indicated as per the procedure for new admission.

(Reviewed 11/03, 12/08)
(Revised 6//00)

P. Advance Dates

The purpose of this procedure is to ensure the smooth, timely transfer of clients between service areas when a direct transfer cannot take place. When an advance date is established, the client does not have to go through the admissions process.

1. If a client is to transfer between service areas, and the time between the service area is less than 30 days, the client will be placed on leave to return to the new program area.
2. If the time between services is 30 days or more, the client is discharged and the Re-Admission Date Form (Advance Date Form) is used. (Template available on WWRC Network Templates). Copies of the Form are sent to Admissions, the Sponsor, and the designated service area.

(Reviewed 11/03, 12/08)
(Revised 6//00)

Q. Transfer of Programs within WWRC

Transfers from one program/service shop to another within WWRC take place frequently and for a variety of reasons as determined by the Rehabilitation Team (the rehabilitation team includes the WWRC case manager, the consumer, the sponsor and all WWRC service providers). When the team determines such a transfer is in the best interest of the consumer, the case manager:

1. Contacts the sponsor/field to confirm approval, verify funding and coordinate any necessary amendments to the IPE (IWRP)
2. Contacts the service area to determine if the consumer meets the criteria for the program, and to determine a date of transfer based on availability of space
3. For those service areas with their own case management, the transferring case manager will contact the receiving case manager and arrange for a smooth transition of case management
4. The transferring case manager will then update the census to reflect the change and, if a change of case management, will deliver case notes and other relevant documentation to the receiving case manager.

(Reviewed 11/03, 12/08)
(Revised 6//00)

R. Student Health Services for Day Students

1. Day students who reside in the local community shall access their home physicians for medical needs. Those clients seeking medical therapies or services provided by the Center should obtain a physician's order that must be submitted to Student Health. The Student Health physician will take the necessary action to ensure appropriate services are provided.

2. Day students who are housed in the local community because of special circumstances, but whose actual residence is outside the local community, may access physician and nursing services through Student Health.
3. If medical services beyond those provided on-site at WWRC are sought, there must be a consultation between the day student's case manager and the Medical Director prior to services being scheduled.
4. All clients, regardless of enrollment status, may receive emergency care for an acute illness or injury (for example, an asthma attack, seizure, laceration, hypoglycemia, chest pain, etc.).
5. Case Managers must review any exceptions or special circumstance cases with the manager of the Counseling Department and the Student Health physician and/or the Medical Director prior to receiving medical services at the Center.
6. Day students shall have prescriptions for medications filled at their local outside pharmacy, with the exception of certain psychotropic medications, or those prescriptions initiated by a WWRC physician.

(Reviewed 11/03, 12/08)
(Revised 11/3/03)

S. Chapter 5

Discharge and Community Integration

I. Community Integration Meeting/Plan

Community Integration Planning begins during the pre-admission phase and continues throughout an individual's enrollment. The preliminary plan is formed based on referral information and telephone contacts with the Person Served, their family, and/or the sponsor. This plan is updated at intake during face to face contact, then further solidified at Plan Development. These plans are kept at the forefront during progress and team meetings throughout the enrollment period.

Forty-five(45) to Sixty Days (60) prior to planned discharge, the Community Integration and Discharge Planning Meeting is held with participation from all service providers, the consumer, and the referral source. All aspects of the consumer's program are reviewed and plans made for optimum successful Community Integration. This is then finalized prior to discharge with the input and assistance of the person served, the and the sponsor in the community.

| ITEM | RESPONSIBILITY | STANDARD |
|-------------------------------|----------------|--|
| Community Integration Meeting | Case Manager | Forty-five (45) - Sixty (60) days prior to anticipated completion date. All Service providers, the referral source/sponsor, the person served and a CES Representative are included. |
| Community Integration Plan | Case Manager | Revised and Finalized prior to or on date of discharge. |

Outcomes

- 1) Determine Immediate Needs to Facilitate Community Integration.
 - 2) Identify Resources Available to Provide Needed Services
 - 3) Identify Person Responsible for Monitoring and Follow-up of Community Integration Plan
- (Reviewed 11/03, 12/08)
(Revised 6/00)

II Discharge

Prior to discharge, the Case Manager will assure that the following items have been completed:

Medication and Discharge Instructions from Student Health (Student Health Nurse)

Turn-In Keys/Name Tag (Dorm Counselor)

Money from Cashier (Cashier)

Discharge Plan/Recommendations for Follow-up (Case Manager)

Transportation Arrangements (PST)

(Reviewed 11/03, 12/08)
(Revised 6/00)

III Discharge Summary

A written Discharge Summary will be mailed to the Sponsor within 21 days of discharge from WWRC. The Summary will include: Reason for Referral, Reason for Discharge, Diagnosis, Rehabilitation Problems, Client Goals, Rehabilitation Goals and Planned Services, Services Provided and Results , Community Integration/Barriers to Employment and Recommendations (See Case Management Forms Template) in the Appendix.

Two weeks after discharge, Records Management begins the audit process. Referrals are checked to ensure that the record contains corresponding reports for services. The counseling discharge report is then reviewed to determine if: 1) it is in the chart and 2) it addresses all services provided as well as the outcomes and recommendations. If the reports are not in the chart, then the first notice is sent to the individual responsible for the report. If not received in 7 days a second notice goes to the individual with a copy to the immediate supervisor. A third notice is generated if the report is not received in the next 7 days with a copy to the immediate supervisor and the respective division head. Seven days later, if the report has still not been received by records, a fourth notice will be sent with a copy to the Center Director, and a Formal Counseling Memo generated informing the employee that a subsequent notice will result in implementation of the Commonwealth of Virginia Standards of Conduct. A fifth notice will result in issuance of a group 1 offense for failure to meet acceptable performance standards.

(Reviewed 05/04)
(Revised 03//06)

IV Follow Up

Although the Center has a follow up survey that is monitored by Organizational Development and Quality Assurance, it is expected that the Case Manager will follow up approximately two weeks after discharge or sooner if felt to be necessary in order to determine progress of the Community Integration Plan. This follow up may be in the form of a phone call and/or visit with the Consumer and/or the sponsor.

(Reviewed 11/03)
(Revised 6//00, 12/08)

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